		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042739

Facility Name: Lexington of Chicago Ridge

Address: 10300 Southwest Highway (Number) Chicago Ridge (City) 60145 (Zip Code)

County: Cook

Telephone Number: (708) 425-1100 **Fax #** (708) 425-0779

IDPA ID Number: 363734823001

Date of Initial License for Current Owners: 05/27/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,435	2,346	8,773	40,554	8
9	SNF/PED					9
10	ICF	30,664	1,307	659	32,630	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,099	3,653	9,432	73,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.51%

D. How many bed-hold days during this year were paid by Public Aid?
148 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/4/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 7,768

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	301,129	31,712	14,089	346,930		346,930		346,930			1
2	Food Purchase		296,026		296,026		296,026	(12,626)	283,400			2
3	Housekeeping	272,735	41,771		314,506		314,506		314,506			3
4	Laundry	68,201	23,648		91,849		91,849	(3,327)	88,522			4
5	Heat and Other Utilities			191,682	191,682		191,682	3,198	194,880			5
6	Maintenance	70,542		126,280	196,822		196,822	(8,292)	188,530			6
7	Other (specify):*											7
8	**TOTAL General Services**	712,607	393,157	332,051	1,437,815		1,437,815	(21,047)	1,416,768			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	3,227,096	239,712	1,625	3,468,433		3,468,433		3,468,433			10
10a	Therapy			1,088,939	1,088,939		1,088,939		1,088,939			10a
11	Activities	184,735	17,146	3,314	205,195		205,195		205,195			11
12	Social Services	61,918		2,280	64,198		64,198		64,198			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,473,749	256,858	1,117,158	4,847,765		4,847,765		4,847,765			16
	C. General Administration											
17	Administrative	193,379		392,453	585,832		585,832	(392,453)	193,379			17
18	Directors Fees											18
19	Professional Services			48,640	48,640		48,640	426	49,066			19
20	Dues, Fees, Subscriptions & Promotions			6,162	6,162		6,162	3,292	9,454			20
21	Clerical & General Office Expenses	413,167	28,325	24,253	465,745		465,745	21,475	487,220			21
22	Employee Benefits & Payroll Taxes			570,276	570,276		570,276	59,267	629,543			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,861	1,861		1,861	1,672	3,533			24
25	Other Admin. Staff Transportation			373	373		373	9,672	10,045			25
26	Insurance-Prop.Liab.Malpractice			119,902	119,902		119,902	2,382	122,284			26
27	Other (specify):*											27
28	**TOTAL General Administration**	606,546	28,325	1,163,920	1,798,791		1,798,791	(294,267)	1,504,524			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,792,902	678,340	2,613,129	8,084,371		8,084,371	(315,314)	7,769,057			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Chicago Ridge #0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
30	Depreciation			42,500	42,500		42,500	175,335	217,835			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34	34		34	332,145	332,179			32
33	Real Estate Taxes							483,643	483,643			33
34	Rent-Facility & Grounds			1,673,360	1,673,360		1,673,360	(1,673,360)				34
35	Rent-Equipment & Vehicles			2,278	2,278		2,278	658	2,936			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,718,172	1,718,172		1,718,172	(681,579)	1,036,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		162,403	14,727	177,130		177,130		177,130			39
40	Barber and Beauty Shops			25,934	25,934		25,934		25,934			40
41	Coffee and Gift Shops			2,974	2,974		2,974		2,974			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable costs			(8,501)	(8,501)		(8,501)	8,501				43
44	**TOTAL Special Cost Centers**		162,403	157,774	320,177		320,177	8,501	328,678			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,792,902	840,743	4,489,075	10,122,720		10,122,720	(988,392)	9,134,328			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(55)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,327)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(24,056)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(790)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,933)	43		18
19	Entertainment				19
20	Contributions	(1,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,619)	43		24
25	Fund Raising, Advertising and Promotional	(9,933)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	33,676	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(4,464)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,501)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(964,891)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (964,891)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (988,392)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/01 - 12/31/01 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collection fees	(6,533)	19
Out of period legal fees	(497)	19
Deferred maintenance amort.	2,566	6
Total	(4,464)	

See Accountants' Compilation Report

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(55)	0	0	0	0	0	0	0	0	0	0	(55)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,327)	0	0	0	0	0	0	0	0	0	0	(3,327)	4
5	Heat and Other Utilities	0	0	3,198	0	0	0	0	0	0	0	0	3,198	5
6	Maintenance	0	(11,924)	1,066	0	0	0	0	0	0	0	0	(10,858)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,382)	(11,924)	4,264	0	0	0	0	0	0	0	0	(11,042)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(392,453)	0	0	0	0	0	0	0	(392,453)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,515	7,406	0	0	0	0	0	0	0	0	15,921	19
20	Fees, Subscriptions & Promotions	0	0	3,292	0	0	0	0	0	0	0	0	3,292	20
21	Clerical & General Office Expenses	0	75	21,400	0	0	0	0	0	0	0	0	21,475	21
22	Employee Benefits & Payroll Taxes	0	0	46,696	0	0	0	0	0	0	0	0	46,696	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,672	0	0	0	0	0	0	0	0	1,672	24
25	Other Admin. Staff Transportation	0	0	9,672	0	0	0	0	0	0	0	0	9,672	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,382	0	0	0	0	0	0	0	2,382	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	8,590	90,138	(390,071)	0	0	0	0	0	0	0	(291,343)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,382)	(3,334)	94,402	(390,071)	0	0	0	0	0	0	0	(302,385)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	162,213	0	13,122	0	0	0	0	0	0	0	175,335	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,056)	354,913	0	1,288	0	0	0	0	0	0	0	332,145	32
33	Real Estate Taxes	0	473,360	0	1,818	0	0	0	0	0	0	0	475,178	33
34	Rent-Facility & Grounds	0	(1,673,360)	0	0	0	0	0	0	0	0	0	(1,673,360)	34
35	Rent-Equipment & Vehicles	0	0	0	658	0	0	0	0	0	0	0	658	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,056)	(682,874)	0	16,886	0	0	0	0	0	0	0	(690,044)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	8,401	100	0	0	0	0	0	0	0	0	0	8,501	43
44	**TOTAL Special Cost Centers**	8,401	100	0	0	0	0	0	0	0	0	0	8,501	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,037)	(686,108)	94,402	(373,185)	0	0	0	0	0	0	0	(983,928)	45

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	22.33%			Sambell of Chicago Ridge		
John Samatas	22.33%	See attached Schedule B		Limited Partnership	Chicago Ridge	Real estate ptsp.
Cynthia Thiem	22.34%			Royal Mgmt. Corp	Lombard	Mgmt. Co.
Jeffrey J. Bell Revocable Trust	8.25%			Lexington Financial		
Lawrence W. Bell Declaration of Trust	8.25%			Services II, L.L.C.	Lombard	Finance Co.
David S. Bell Declaration of Trust	8.25%					
Dorothy D. Bell Declaration of Trust	8.25%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,673,360	Sambell of Chicago Ridge Limited Partnership	**	$	$ (1,673,360)	1
2	V	19	Professional fees		Sambell of Chicago Ridge Limited Partnership	**	8,515	8,515	2
3	V	21	Office supplies expense		Sambell of Chicago Ridge Limited Partnership	**	75	75	3
4	V	6	Maintenance	11,924	Sambell of Chicago Ridge Limited Partnership	**		(11,924)	4
5	V	30	Depreciation		Sambell of Chicago Ridge Limited Partnership	**	162,213	162,213	5
6	V	32	Interest expense		Sambell of Chicago Ridge Limited Partnership	**	351,704	351,704	6
7	V	32	Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	3,209	3,209	7
8	V	33	Property taxes		Sambell of Chicago Ridge Limited Partnership	**	473,360	473,360	8
9	V	43	State replacement tax		Sambell of Chicago Ridge Limited Partnership	**	100	100	9
10	V					**			10
11	V				** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V				of Sambell of Chicago Ridge Limited Partnership				12
13	V								13
14	Total			$ 1,685,284			$ 999,176	$ * (686,108)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	Utilities - gas & electric	$	Royal Management Corp.	**	$ 2,829	$ 2,829	15
16	V		5	Utilities - water & sewer		Royal Management Corp.	**	369	369	16
17	V		6	Repairs & maintenance		Royal Management Corp.	**	742	742	17
18	V		6	Scavenger & exterminating		Royal Management Corp.	**	310	310	18
19	V		6	Security service		Royal Management Corp.	**	14	14	19
20	V		19	Computer consultant & supplies		Royal Management Corp.	**	5,663	5,663	20
21	V		19	Professional fees		Royal Management Corp.	**	1,743	1,743	21
22	V		20	Advertising - help wanted		Royal Management Corp.	**	2,694	2,694	22
23	V		20	Dues & subscriptions		Royal Management Corp.	**	598	598	23
24	V		21	Bank charges		Royal Management Corp.	**	3,226	3,226	24
25	V		21	Communications		Royal Management Corp.	**	583	583	25
26	V		21	Office supplies & printing		Royal Management Corp.	**	6,960	6,960	26
27	V		21	Postage		Royal Management Corp.	**	2,939	2,939	27
28	V		21	Telephone		Royal Management Corp.	**	7,692	7,692	28
29	V		22	FICA		Royal Management Corp.	**	28,646	28,646	29
30	V		22	FUTA		Royal Management Corp.	**	591	591	30
31	V		22	SUTA		Royal Management Corp.	**	1,119	1,119	31
32	V		22	Insurance - W/C		Royal Management Corp.	**	361	361	32
33	V		22	Insurance - Hospitalization		Royal Management Corp.	**	11,962	11,962	33
34	V		22	401(k) and other emp. benefits		Royal Management Corp.	**	4,017	4,017	34
35	V		24	Travel & seminar		Royal Management Corp.	**	1,672	1,672	35
36	V		25	Auto expense		Royal Management Corp.	**	9,672	9,672	36
37	V									37
38	V			** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total				$			$ 94,402	$ * 94,402	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - general	$	Royal Management Corp.	**	$ 2,382	$ 2,382	15
16	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,027	4,027	16
17	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,479	2,479	17
18	V	30	Depreciation - equipment		Royal Management Corp.	**	6,616	6,616	18
19	V	32	Interest		Royal Management Corp.	**	1,288	1,288	19
20	V	33	Property taxes		Royal Management Corp.	**	1,818	1,818	20
21	V	35	Equipment rental		Royal Management Corp.	**	658	658	21
22	V	17	Management	392,453	Royal Management Corp.	**		(392,453)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 392,453			$ 19,268	$ * (373,185)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996 **Schedule B**
1/1/01 - 12/31/01

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	5	11.00%	Salary	$ 40,322	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10.00%	Salary	17,732	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10.00%	Salary	22,250	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10.00%	Salary	9,084	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12.00%	Salary	12,260	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 101,648		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996 **Schedule C**
1/1/01 - 12/31/01

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	145,293	330,395	182,313	74,433	100,457	832,891

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	$ 26,007	$	81,760	$ 2,829	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397		81,760	369	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818		81,760	742	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851		81,760	310	4
5	6	Security Service	Bed Days	751,703	11	125		81,760	14	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068		81,760	5,663	6
7	19	Professional fees	Bed Days	751,703	11	16,027		81,760	1,743	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766		81,760	2,694	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496		81,760	598	9
10	21	Bank charges	Bed Days	751,703	11	29,664		81,760	3,226	10
11	21	Communications	Bed Days	751,703	11	5,359		81,760	583	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988		81,760	6,960	12
13	21	Postage	Bed Days	751,703	11	27,021		81,760	2,939	13
14	21	Telephone	Bed Days	751,703	11	70,716		81,760	7,692	14
15	22	FICA	Bed Days	751,703	11	263,374		81,760	28,646	15
16	22	FUTA	Bed Days	751,703	11	5,433		81,760	591	16
17	22	SUTA	Bed Days	751,703	11	10,292		81,760	1,119	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319		81,760	361	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982		81,760	11,962	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931		81,760	4,017	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373		81,760	1,672	21
22	25	Auto expense	Bed Days	751,703	11	88,927		81,760	9,672	22
23										23
24										24
25	TOTALS					$ 867,934	$		$ 94,402	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance - general	Bed Days	751,703	11	$ 21,896	$	81,760	$ 2,382	1
2	30	Depreciation - vehicles	Bed Days	751,703	11	37,022		81,760	4,027	2
3	30	Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		81,760	2,479	3
4	30	Depreciation - equipment	Bed Days	751,703	11	60,826		81,760	6,616	4
5	32	Interest	Bed Days	751,703	11	11,844		81,760	1,288	5
6	33	Property taxes	Bed Days	751,703	11	16,719		81,760	1,818	6
7	35	Equipment rental	Bed Days	751,703	11	6,049		81,760	658	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 177,145	$		$ 19,268	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, L.L.C.	X		Mortgage	Varies	12/29/98	5,563,000	5,138,524	01/01/08	0.0675	351,704	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,563,000	$ 5,138,524			$ 351,704	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			3,209	10
11								Interest income offset			(24,056)	11
12								Allocated from management company			1,288	12
13								Miscellaneous interest			34	13
14	TOTAL Non-Facility Related						$	$			$ (19,525)	14
15	TOTALS (line 9+line14)						$ 5,563,000	$ 5,138,524			$ 332,179	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 468,000	1
	Allocation from management company	1,818	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 478,861	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,679	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 492,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 8,465	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 29,501 **For** 19 96-97 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (29,501)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 483,643	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	394,238	8
	1997	404,097	9
	1998	442,475	10
	1999	462,509	11
	2000	478,861	12

2000 taxes:	478,861
Estimated increase (1.03%):	1.03
Estimated 2001 taxes:	490,832
Use:	492,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Chicago Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036996

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-200-030-0000	Land and building	$ 478,860.68	$ 478,860.68
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 68,214.22	$ 1,818.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 547,074.90	$ 480,678.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	31,000	1989	$ 505,000	1
2					2
3	TOTALS	31,000		$ 505,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1991	1991	$ 5,143,342	$	35	$ 146,953	$ 146,953	$ 1,555,250	4
5	9		1995	1995	97,352	2,781	35	2,781		18,080	5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	2,694	78	35	78		655	9
10	Leasehold Improvements			1994	6,581	188	35	188		1,410	10
11	Dishwasher hood			1996	2,480	248	10	248		1,364	11
12	Lobby repairs			1996	8,698	870	10	870		4,784	12
13	Basement rehab			1997	24,477	2,448	10	2,448		11,830	13
14	Wiring			1998	3,428	343	10	343		1,200	14
15	Handrails			1998	895	60	15	60		209	15
16	Resurface & restripe parking lot			1998	4,450	445	10	445		1,558	16
17	Fire wall			1998	2,169	62	35	62		217	17
18	Foyer floor tile			1999	32,379	3,238	10	3,238		9,174	18
19	Wallpapering / painting / decorating			1999	8,833	883	10	883		1,987	19
20	Rebuild garage area			1999	1,762	50	35	50		109	20
21	Roof repairs			2000	6,240	624	10	624		936	21
22	Electrical wiring			2000	3,986	114	35	114		171	22
23	Electrical wiring			2000	2,536	72	35	72		109	23
24	Kitchen rehab			2000	6,623	221	35	221		331	24
25	Automatic doors			2000	1,300	130	10	130		195	25
26	Elevator eye sensors			2000	4,500	300	15	300		450	26
27	Resurface & restripe parking lot			2001	3,319	166	10	166		166	27
28	Door releases			2001	5,200	260	10	260		260	28
29	Carpeting			2001	10,022	501	10	501		501	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocated from management company	1995	$ 10,923	$		$ 338	$ 338	$ 2,029	37
38	Allocated from management company	1996	8,890			275	275	1,397	38
39	Allocated from management company	1989	306			9	9	134	39
40	Allocated from management company - HVAC	1998	230			7	7	26	40
41	Allocated from management company - Offices	1999	581			18	18	42	41
42	Allocated from management company - Offices	2000	276			9	9	14	42
43	Allocated from management company	1987	56,207			1,741	1,741	24,616	43
44	Allocated from management company	1993	30			1	1	6	44
45	Allocated from management company	1995	1,266			39	39	210	45
46	Allocated from management company	1996	254			8	8	34	46
47	Allocated from management company - Sidewalk	1998	529			16	16	46	47
48	Allocated from management company - Roof	1998	19			1	1	6	48
49	Allocated from management company - Awnings	1999	149			5	5	10	49
50	Allocated from management company - Parking lot	1999	327			10	10	75	50
51	Allocated from management company - Facade	2001	46			1	1	1	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,463,299	$ 14,082		$ 163,514	$ 149,432	$ 1,639,592	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 570,075	$ 28,327	$ 41,111	$ 12,784	5-10 years	$ 479,556	71
72	Current Year Purchases	27,607		2,567	2,567	5-10 years	2,567	72
73	Fully Depreciated Assets	28,598					28,598	73
74	Allocated from Mgmt Co.	71,466		6,616	6,616		51,927	74
75	TOTALS	$ 697,746	$ 28,327	$ 50,294	$ 21,967		$ 562,648	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	1994 Infiniti	1994	$ 19,313	$	$	$		$ 19,313	76
77										77
78										78
79	Allocated from Mgmt Co.			32,352		4,027	4,027		21,075	79
80	TOTALS			$ 51,665	$	$ 4,027	$ 4,027		$ 40,388	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,717,710	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,409	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 217,835	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 175,426	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,242,628	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Roof replacement	$ 12,800	92
93			93
94			94
95		$ 12,800	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,936 Description: Copier: $2,278; Allocation from management company: $658
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	42,755	$ 505,358	$	42,755	$ 505,358	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		946	14,618		946	14,618	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		55,491	568,963		55,491	568,963	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				162,403		162,403	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					14,727			14,727	13
14	TOTAL			$	99,192	$ 1,103,666	$ 162,403	99,192	$ 1,266,069	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996 **Schedule D**
1/1/01 - 12/31/01

XIV. Special Services
Line 13, Other:

Service	Cost	Line Reference
Oxygen	2,878	L39, C3
Radiology	7,020	L39, C3
Laboratory	3,139	L39, C3
Clinitron Beds	1,490	L39, C3
Dentist	200	L39, C3
Total	14,727	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 136,509	$ 146,875	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 529,106)	2,772,408	2,772,408	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,630	57,630	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	141,052	141,275	8
9	Other(specify): Escrow		96,155	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,107,599	$ 3,214,343	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,072	6,072	12
13	Land		505,000	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	239,924	319,957	15
16	Equipment, at Historical Cost	236,179	749,411	16
17	Accumulated Depreciation (book methods)	(179,481)	(2,242,628)	17
18	Deferred Charges		2,851	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Mortgage Costs	12,800	67,346	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 315,494	$ 4,551,351	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,423,093	$ 7,765,694	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 421,620	$ 421,620	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,571	128,571	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,172	3,172	31
32	Accrued Real Estate Taxes(Sch.IX-B)		492,000	32
33	Accrued Interest Payable		28,904	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	487,264	96,953	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,040,627	$ 1,171,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,138,524	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,138,524	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,040,627	$ 6,309,744	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,382,466	$ 1,455,950	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,423,093	$ 7,765,694	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/01 - 12/31/01 **Schedule E**

XV. Balance Sheet
C. Current Liabilities
36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	390,311	-
Accrued management fees	29,623	29,623
Accrued 401(k) contribution	23,935	23,935
Other accrued expenses	43,395	43,395
Total line 36	487,264	96,953

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment Income	1,557
State bedhold Income	10,241
Miscellaneous Income	3,695
Total line 28	15,493

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,877,316	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,877,316	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,252,150	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(747,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 505,150	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,382,466	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,891,455	1
2	Discounts and Allowances for all Levels	(631,716)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,259,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,766,639	6
7	Oxygen	(217)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,766,422	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,900	12
13	Barber and Beauty Care	32,703	13
14	Non-Patient Meals	55	14
15	Telephone, Television and Radio	78	15
16	Rental of Facility Space		16
17	Sale of Drugs	157,800	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,995	19
20	Radiology and X-Ray	6,890	20
21	Other Medical Services	94,412	21
22	Laundry	3,327	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 309,160	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,056	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,056	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	15,493	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,493	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,374,870	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,437,815	31
32	Health Care	4,847,765	32
33	General Administration	1,798,791	33
	B. Capital Expense		
34	Ownership	1,718,172	34
	C. Ancillary Expense		
35	Special Cost Centers	197,537	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,122,720	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,252,150	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,252,150	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,079	2,175	$ 98,401	$ 45.24	1
2	Assistant Director of Nursing	4,656	4,990	143,023	28.66	2
3	Registered Nurses	59,963	64,538	1,479,469	22.92	3
4	Licensed Practical Nurses	6,559	7,202	150,503	20.90	4
5	Nurse Aides & Orderlies	109,395	114,724	1,221,232	10.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,395	11,414	134,468	11.78	8
9	Activity Director	1,782	2,030	26,189	12.90	9
10	Activity Assistants	17,117	18,181	158,546	8.72	10
11	Social Service Workers	4,063	4,200	61,918	14.74	11
12	Dietician	113	121	3,368	27.83	12
13	Food Service Supervisor	2,294	2,468	24,018	9.73	13
14	Head Cook	3,014	3,295	32,360	9.82	14
15	Cook Helpers/Assistants	15,149	16,054	143,146	8.92	15
16	Dishwashers	15,877	16,293	98,237	6.03	16
17	Maintenance Workers	4,284	4,591	70,542	15.37	17
18	Housekeepers	38,861	41,110	272,735	6.63	18
19	Laundry	10,001	10,661	68,201	6.40	19
20	Administrator	2,001	2,047	91,731	44.81	20
21	Assistant Administrator					21
22	Other Administrative	746	751	101,648	135.35	22
23	Office Manager					23
24	Clerical	23,058	24,899	413,167	16.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	331,407	351,744	$ 4,792,902 *	$ 13.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,089	L1, C3	35
36	Medical Director	Monthly	21,000	L9, C3	36
37	Medical Records Consultant	9	425	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,314	L11, C3	44
45	Social Service Consultant	Monthly	2,280	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	$ 42,308		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Cecconi	Administrator	0.00%	$ 91,731
John Samatas	Admin/Plant Ops	22.33%	17,732
James Samatas	Administrative	22.33%	40,322
Cynthia Thiem	Administrative	22.34%	22,250
George Samatas	Administrative	0.00%	9,084
Jason Samatas	Administrative	0.00%	12,260
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 193,379

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 392,453
TOTAL (agree to Schedule V, line 17, col. 3)	$ 392,453
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Ins. & Annuity Co.	401(k) Administration	$ 645
Altschuler, Melvoin & Glasser LLP	Accounting	13,358
American Express Tax & Bus. Svcs.	Accounting	6,634
Robert Stachura	Accounting	27
Health & Safety Associates	OSHA Complaint Consulting	150
James Samatas	Legal	50
Personnel Planners	U/C Consulting	1,065
Royal Management	Website Development	369
Sachnoff & Weaver	Legal	6,289
Systematic Management	Billing Consulting	9,076
Environetx	Space Consulting	242
See attached Schedule F		10,735
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,640

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,136
Unemployment Compensation Insurance	29,398
FICA Taxes	361,515
Employee Health Insurance	133,733
Employee Meals	12,571
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	26,495
Other Employee Benefits	14,695
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,543

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	3,774
Health Care Worker Background Check	
(Indicate # of checks performed 43)	516
Miscellaneous Dues & Subs	135
Miscelleneous Licenses & Permits	1,337
Allocated from management company	3,292
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,454

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,861
See attached detail	
Allocated from management company	1,672
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,533

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996 **Schedule F**
1/1/01 - 12/31/01

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Freidman, Anselmo & Lindberg	Collections	6,533
AIM	Computer Services	2,735
ICI	Computer Services	1,467
		10,735
Total, Agrees to Schedule V, Line 19, Column 3		48,640
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	1,129
James Samatas	Filing and recording fees	4
Sachnoff & Weaver	Legal	56
BDO Seidman, LLP	Accounting	17
Robert Stachura	Accounting	2
Pension Administrators / Aetna Life Ins & Annuity	401 (k) Administration	239
Various	Consulting	296
Various	Computer Services	5,663
Allocated from building partnership		
James Samatas	Filing and recording fees	50
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	8,465
Nonallowable legal fees		
Sachnoff & Weaver	Legal	(497)
Freidman, Anselmo, & Lindberg	Collection fees	(6,533)
Reclassifications		
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	(8,465)
Total, Agrees to Schedule V, Line 19, Column 8		49,066

See accountants' compilation report.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred painting & dec	Various 98	$ 3,991	3 years	$ 665	$ 1,330	$ 1,330	$ 666	$	$	$	$	$
2	Deferred painting & dec	12/99	2,198	3 years			367	732	732	367			
3	Deferred painting & dec	12/00	3,503	3 years			583	1,168	1,168	584			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,692		$ 665	$ 1,330	$ 2,280	$ 2,566	$ 1,900	$ 951	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **71,067** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,571** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **55**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	301,129	31,712	14,089	346,930	0	346,930	0	346,930
2. Food Pu	0	296,026	0	296,026	0	296,026	-12,626	283,400
3. Housek	272,735	41,771	0	314,506	0	314,506	0	314,506
4. Laundry	68,201	23,648	0	91,849	0	91,849	-3,327	88,522
5. Heat an	0	0	191,682	191,682	0	191,682	3,198	194,880
6. Mainten	70,542	0	126,280	196,822	0	196,822	-8,292	188,530
7. Other (s	0	0	0	0	0	0	0	0
8. Total Ge	712,607	393,157	332,051	1,437,815	0	1,437,815	-21,047	1,416,768
9. Medical	0	0	21,000	21,000	0	21,000	0	21,000
10. Nursin	3,227,096	239,712	1,625	3,468,433	0	3,468,433	0	3,468,433
10a. Thera	0	0	1,088,939	1,088,939	0	1,088,939	0	1,088,939
11. Activiti	184,735	17,146	3,314	205,195	0	205,195	0	205,195
12. Social	61,918	0	2,280	64,198	0	64,198	0	64,198
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	3,473,749	256,858	1,117,158	4,847,765	0	4,847,765	0	4,847,765
17. Admin	193,379	0	392,453	585,832	0	585,832	-392,453	193,379
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	48,640	48,640	0	48,640	426	49,066
20. Fees,	0	0	6,162	6,162	0	6,162	3,292	9,454
21. Clerica	413,167	28,325	24,253	465,745	0	465,745	21,475	487,220
22. Emplo	0	0	570,276	570,276	0	570,276	59,267	629,543
23. Inservi	0	0	0	0	0	0	0	0
24. Travel	0	0	1,861	1,861	0	1,861	1,672	3,533
25. Other	0	0	373	373	0	373	9,672	10,045
26. Insura	0	0	119,902	119,902	0	119,902	2,382	122,284
27. Other	0	0	0	0	0	0	0	0
28. Total G	606,546	28,325	1,163,920	1,798,791	0	1,798,791	-294,267	1,504,524
29. Total C	4,792,902	678,340	2,613,129	8,084,371	0	8,084,371	-315,314	7,769,057
30. Depre	0	0	42,500	42,500	0	42,500	175,335	217,835
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	34	34	0	34	332,145	332,179
33. Real E	0	0	0	0	0	0	483,643	483,643
34. Rent -	0	0	1,673,360	1,673,360	0	1,673,360	########	0
35. Rent -	0	0	2,278	2,278	0	2,278	658	2,936
36. Other	0	0	0	0	0	0	0	0
37. Total G	0	0	1,718,172	1,718,172	0	1,718,172	-681,579	1,036,593
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	162,403	14,727	177,130	0	177,130	0	177,130
40. Barber	0	0	25,934	25,934	0	25,934	0	25,934
41. Coffee	0	0	2,974	2,974	0	2,974	0	2,974
42. Provid	0	0	122,640	122,640	0	122,640	0	122,640
43. Other	0	0	-8,501	-8,501	0	-8,501	8,501	0
44. Total S	0	162,403	157,774	320,177	0	320,177	8,501	328,678
45. Grand	4,792,902	840,743	4,489,075	########	0	########	-988,392	9,134,328

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	136,509	146,875
2. Cash - F	0	0
3. Account	2,772,408	2,772,408
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	57,630	57,630
7. Other Pr	0	0
8. Account	141,052	141,275
9. Other (s	0	96,155
10. Total cı	3,107,599	3,214,343
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	6,072	6,072
13. Land	0	505,000
14. Buildin	0	5,143,342
15. Leaseh	239,924	319,957
16. Equipm	236,179	749,411
17. Accum	-179,481	########
18. Deferre	0	2,851
19. Organi:	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	12,800	67,346
24. Total L	315,494	4,551,351
25. Total A	3,423,093	7,765,694
CURRENT LIABILITIES		
26. Accour	421,620	421,620
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	128,571	128,571
31. Accrue	3,172	3,172
32. Accrue	0	492,000
33. Accrue	0	28,904
34. Deferre	0	0
35. Federa	0	0
36. Other C	487,264	96,953
37. Other C	0	0
38. Total C	1,040,627	1,171,220
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	5,138,524
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	5,138,524
46.Total Li	1,040,627	6,309,744
47.Total Ec	2,382,466	1,455,950
48.Total Li	3,423,093	7,765,694

		Balance per Medicaid Trial Balance
1.	Gross F	9,891,455
2.	Discour	-631,716
	Subtota	9,259,739
4.	Day Ca	0
5.	Other C	0
6.	Therapy	1,766,639
7.	Oxygen	-217
	Subtota	1,766,422
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	3,900
13.	Barber	32,703
14.	Non-P	55
15.	Teleph	78
16.	Rental	0
17.	Sale o	157,800
18.	Sale o	0
19.	Labora	9,995
20.	Radiol	6,890
21.	Other	94,412
22.	Laund	3,327
	Subtot	309,160
24.	Contril	0
25.	Interes	24,056
	Subtot	24,056
27.	Other	15,493
28.	Other	0
	Subtot	15,493
30.	Total F	########
31.	Gener	1,437,815
32.	Health	4,847,765
33.	Gener	1,798,791
34.	Owner	1,718,172
35.	Specia	197,537
35.	Provid	122,640
37.	Other	0
40.	Total E	########
41.	Incom	1,252,150
42.	Incom	0
43.	Net In	1,252,150

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Lexington of Chicago Ri** **03:14 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-988,392	equal to	-988,392	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	332,179	equal to	332,179	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	483,643	equal to	483,643	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	217,835	equal to	217,835	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,936	equal to	2,936	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,088,939	equal to	1,088,939	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	162,403	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,437,815	equal to	1,437,815	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,847,765	equal to	4,847,765	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,798,791	equal to	1,798,791	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,718,172	equal to	1,718,172	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	197,537	equal to	197,537	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,092,628	equal to	3,227,096	-134,468	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	184,735	equal to	184,735	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	61,918	equal to	61,918	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	301,129	equal to	301,129	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	70,542	equal to	70,542	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	272,735	equal to	272,735	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	68,201	equal to	68,201	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	193,379	equal to	193,379	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	413,167	equal to	413,167	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,792,902	equal to	4,792,902	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	14,089	< or = to	14,089	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	21,000	< or = to	21,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,625	< or = to	1,625	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,314	< or = to	3,314	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,280	< or = to	2,280	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	193,379	equal to	193,379	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	392,453	equal to	392,453	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	48,640	equal to	48,640	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	629,543	equal to	629,543	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,454	equal to	9,454	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,533	equal to	3,533	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	12,571	< or = to	59,267	-46,696	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	12,571	equal to	12,571	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,768	equal to	8,773	-1,005	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-964,891	equal to	-964,891	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,138,524	equal to	5,138,524	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	492,000	equal to	492,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	505,000	equal to	505,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,463,299	equal to	5,463,299	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	749,411	equal to	749,411	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,242,628	equal to	2,242,628	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,382,466	equal to	2,382,466	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	1,252,150	equal to	1,252,150	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	2,851	equal to	2,851	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,423,093	equal to	3,423,093	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1